YOUTH FUNDING EXTENSION AUTHORIZATION

EHR # _____

Today's Date: _____

Extension at ☐ 5 days ☐ 10 days ☐ 13 days ☐ Other _____ (please note # days)

Client Information

1. First Name: _____ 2. MI _____ 3. Last Name _____

4. Social Security Number: _____ / _____ / _____ 5. Admission Date: _____ / _____ / _____

6. Hospital: ☐ Dominion ☐ Poplar Springs ☐ Snowden

7. Authorizing CSB: ☐ Alexandria ☐ Arlington ☐ Fairfax ☐ Loudoun ☐ Prince William

Reauthorization not to exceed 5 days. Extensions require approval of participating CSB and submission of this Extension Form to the Regional Projects Office and treating hospital**.**

8. Authorizing Criteria Met: (check all that apply)
   1) ☐ Confirmed Diagnosis of mental illness, and/or
   2) ☐ Clinical evidence indicates persistence of symptoms that caused initial admission, or remain despite therapeutic efforts, or due to the emergence of new symptoms, and/or
   3) ☐ Reaction to medication or further monitoring/adjustment of dosages (daily progress note required)
   4) ☐ Other:

The client identified above is referred to your facility for continued acute inpatient treatment. The referring Community Services Board shall determine the client's eligibility for extended admission.

The CSB Discharge Planner may grant the first project reauthorization approval for up to 5 days. Further extensions will be a joint decision with the Regional Projects Office, the Youth Director or designee, and the CSB Discharge Planner.

9. Reauthorization for (# up to 5) ____ days to _____ / _____ / _____

10. Authorizing Representative: _____ Date: _____ / _____ / _____

Last Updated: 12/1/12

Fax to NVRPO, attention Julie Parkhurst @ 703-968-4020